



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **600 PAOLI POINTE DRIVE OPERATIONS LLC**

LEGAL ENTITY

To operate **HIGHGATE AT PAOLI POINTE**

NAME OF FACILITY OR AGENCY

Located at **600 PAOLI POINTE DRIVE, PAOLI, PA 19301**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **124**

or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 30**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 19, 2025** until **December 19, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **136100**


ISSUING OFFICER


DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable
and should be posted in a conspicuous place in the facility.

HS 628 - 04/23



Pennsylvania Department of Human Services

Emailing date: December 19, 2025

[REDACTED]
[REDACTED]

600 Paoli Pointe Drive Operations LLC
600 Paoli Pointe Drive
Paoli, Pennsylvania 19301

RE: Highgate at Paoli Pointe
License #: 136100

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on August 11 and 12, 2025 and October 23, 2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in cursive script that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY

December 16, 2025

[REDACTED]
600 PAOLI POINTE DRIVE OPERATIONS LLC
600 PAOLI POINTE DRIVE
PAOLI, PA, 19301

RE: HIGHGATE AT PAOLI POINTE
600 PAOLI POINTE DRIVE
PAOLI, PA, 19301
LICENSE/COC#: 13610

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/11/2025, 08/12/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: HIGHGATE AT PAOLI POINTE

License #: 13610

License Expiration: 10/11/2025

Address: 600 PAOLI POINTE DRIVE, PAOLI, PA 19301

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: 600 PAOLI POINTE DRIVE OPERATIONS LLC

Address: 600 PAOLI POINTE DRIVE, PAOLI, PA, 19301

Phone: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 05/15/1996

Issued By: COPA L & I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 50

Waking Staff: 38

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Complaint, Provisional, Monitoring

Exit Conference Date: 08/12/2025

Inspection Dates and Department Representative

08/11/2025 - On-Site: [REDACTED]

08/12/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 124

Residents Served: 33

Secured Dementia Care Unit

In Home: Yes

Area: 3rd floor

Capacity: 30

Residents Served: 14

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 33

Diagnosed with Mental Illness: 1

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 17

Have Physical Disability: 1

Inspections / Reviews

08/11/2025 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 09/30/2025

12/16/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/24/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 8/11/2025:

- the posted license to operate a retail food facility, issued by the Chester County Health Department, had an expiration date of 5/31/2025.
- a Carbon Monoxide detector was not located in the vicinity of the boiler room. According to the Care Facility Carbon Monoxide Alarms Standards Act dated Jun. 23, 2016, Carbon monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: The administrator or designee shall contact the Chester County Health Department to renew the license to operate a retail food facility.

Immediately: a Carbon Monoxide detector shall be installed in the vicinity of the boiler room in accordance with the Care Facility Carbon Monoxide Alarms Standards Act dated Jun. 23, 2016.

Directed Completion Date: 09/26/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

63a - First Aid/CPR Training

2. Requirements

2600.

- 63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 8/3/2025 and 8/7/2025, from 7:00 AM to 3:00 PM, 33 residents were present in the home. During this time no staff persons were present in the home who were certified in obstructed airway techniques and CPR.

Repeat violation: 9/17/24 et al

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: The administrator or designee who schedules staff shall ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation will be present in the home at all times.

63a - First Aid/CPR Training (continued)

Within 3 days of the receipt of this plan of correction: The administrator or designee who schedules staff shall develop and implement a system that ensures at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation will be present in the home at all times. Documentation shall be kept for review by the Department.

Directed Completion Date: 09/28/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

64c - Annual Training**3. Requirements**

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the [REDACTED], completed 0 hours of Department-approved training in training year 2024.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: An annual staff training plan shall be developed for the administrator which includes 24 hours of Department-approved training. Documentation shall be kept for review by the Department.

Immediately: Administrator training shall be monitored monthly and through the quality management process to ensure each administrator has 24 hours of Department approved training annually. Documentation shall be kept for review by the Department.

Directed Completion Date: 09/26/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

65a - FS Orientation 1st Day**4. Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [REDACTED]/2025, did not receive orientation on the following topics: evacuation

65a - FS Orientation 1st Day (continued)

procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat violation: 6/18/25, 9/17/24 et al

Plan of Correction**Directed** [REDACTED] **- 09/25/2025)**

Immediately: Staff person B shall receive orientation on evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services. Documentation shall be kept in accordance with 2600.65i.

Within 3 days of receipt of the plan of correction: The administrator or designated staff person shall review all current staff person training records to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in general fire safety and emergency preparedness in accordance with regulation 2600.65a. Documentation of the review shall be kept for review by the Department.

Within 3 days of receipt of the plan of correction: The administrator or designated staff person shall create a tracking system for new hires to ensure that newly-hired staff persons receive the training required by this regulation on or before the first work day and the documentation of training is kept in the staff person's record. Documentation shall be kept for review by the Department.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented** [REDACTED] **12/16/2025)**

See attached.

65b - Rights/Abuse 40 Hours**5. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed [REDACTED] r 40th scheduled work hour prior to [REDACTED] 2025. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and

65b - Rights/Abuse 40 Hours (continued)

neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) or reporting of reportable incidents and conditions until 5/3/2025.

Repeat violation: 6/18/25, 9/17/24 et al

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Within 3 days of receipt of the plan of correction: The administrator or designated staff person shall review all new staff person training records to ensure all new staff persons including ancillary staff persons, substitute personnel and volunteers have received orientation in resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions in accordance with regulation 2600.65b within 40 scheduled working hours. Documentation of the review shall be kept for review by the Department.

Within 3 days of receipt of the plan of correction: The administrator or designated staff person shall create a tracking system for new hires to ensure that newly-hired staff persons receive the training required by this regulation within 40 scheduled working hours and the documentation of training is kept in the staff person's record. Documentation shall be kept for review by the Department.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented [REDACTED] - 12/16/2025)**

See attached.

82c - Locking Poisonous Materials**6. Requirements**

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 8/11/2025:

- at 9:44 AM, Rapid Multi Surface Disinfectant Cleaner, with a manufacturer's label indicating "contact poison control if ingested", was unlocked, unattended, and accessible to residents in an unlocked housekeeping closet on the Memory Care Unit. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.*
- at 9:50 AM, Listerine Ultra Clean mouthwash with a manufacturer's label indicating "contact poison control if ingested in large quantities", was unlocked, unattended, and accessible to residents in room 308. Not all the residents of the home, including resident 1, have been assessed capable of recognizing and using poisons safely.*
- at 9:55 AM, Instant Hand Sanitizer Wipes with a manufacturer's label indicating "if swallowed contact poison control and get medical help right away", were unlocked, unattended, and accessible to residents in room 315. Not all the residents of the home, including resident 2, have been assessed capable of recognizing and using poisons safely.*

Repeat violation: 11/26/24, 3/20/25

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Immediately: A designated staff person shall check the home daily on each shift to ensure poisonous materials are

82c - Locking Poisonous Materials (continued)

locked and inaccessible to residents. Documentation shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons shall be educated concerning the safe storage of poisonous materials and the risks to residents. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

See attached.

Implemented ( **12/16/2025)**

85a - Sanitary Conditions**7. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/11/2025:

- at 9:45 AM, the refrigerator in the Memory Care unit had multiple brown spills and sticky substances on the interior.*
- at 10:17 AM, there was pink slimy mold on the interior of the ice machine in the main kitchen.*
- there were brown smears, which appeared to be feces, in the shower of room 310.*

Plan of Correction

Directed  **- 09/25/2025)**

Immediately: A designated staff person shall monitor the home at least daily on each shift to ensure sanitary conditions are maintained. Documentation shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons shall be re-educated on maintaining sanitary conditions including immediately correcting or reporting any unsanitary conditions. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

See attached.

Implemented ( **- 12/16/2025)**

85e - Trash Outside Home**8. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/11/2025, at 9:34 AM, the lids of the dumpsters in the back of the home were not closed.

85e - Trash Outside Home (continued)**Plan of Correction****Directed** [REDACTED] - 09/25/2025)

Immediately: A designated staff person shall check the dumpster and any other outside trash receptacles on each shift to ensure the garbage dumpster and any other outside trash receptacles are covered. Documentation shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons will be educated on the requirement to keep trash in covered receptacles and to notify the administrator when the garbage dumpster is full. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented** [REDACTED] - 12/16/2025)

See attached.

88a - Surfaces**9. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 8/11/2025:

- *at 9:15 AM, there was a ceiling tile missing in the women's bathroom on the Terrace Level.*
- *there was peeling paint on the walls in the Memory Care hallway, by the emergency exit.*

Repeat violation: 6/18/25, 4/30/25, 11/26/24, 9/17/24

Plan of Correction**Directed** [REDACTED] - 09/25/2025)

Immediately: The administrator or designee shall check all areas of the home at least daily to ensure floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Hazardous conditions will be corrected immediately. Documentation shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons shall be educated on reporting and or correcting any floors, walls, ceilings and other surfaces that are not clean, not in good repair or are hazardous. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented** [REDACTED] - 12/16/2025)

See attached.

95 - Furniture and Equipment**10. Requirements**

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

95 - Furniture and Equipment (*continued*)**Description of Violation**

The hardware to open the bathroom cabinet in room 308 is missing.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: the hardware for the bathroom cabinet in room 308 shall be replaced.

Immediately: A designee shall check the home daily to ensure furniture and equipment is in good repair, clean and free of hazards. Any hazards will be immediately corrected. If furniture or equipment is in disrepair and cannot be repaired immediately it will be immediately removed from service. Documentation shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons shall be educated on the requirements of regulation 2600.95 and reporting or repairing furniture and equipment that is not in good repair, not clean or is hazardous. Any hazards will be immediately corrected. If furniture or equipment is in disrepair and cannot be repaired immediately, it will be immediately removed from service. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

100a - Exterior - Free of Hazards

11. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 8/11/2025, at 1:38 PM, ground cover was overgrown and coming out of the garden area, covering the sidewalk.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: The administrator or designated staff person shall conduct a monthly assessment of the exterior of the building, building grounds and yard to ensure all areas are in good repair and free of hazards. Any hazards will be immediately corrected. Documentation of checks shall be kept.

Directed Completion Date: 09/26/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

101j5 - Bedside Table/Shelf

12. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident 1's bed in bedroom 308.

There is no bedside table or shelf beside resident 2's bed in bedroom 315.

101j5 - Bedside Table/Shelf (continued)**Plan of Correction****Directed** [REDACTED] - 09/25/2025)*Immediately: A bedside table or shelf shall be placed by residents 1 and 2's beds.**Immediately: A designated staff person shall do an initial check of all resident rooms, then at least weekly thereafter, to ensure each resident has a bedside table or shelf. Documentation of checks shall be kept.***Directed Completion Date:** 09/26/2025**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.***101j7 - Lighting/Operable Lamp****13. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation*Resident 1 does not have access to a source of light that can be turned on/off at bedside.**Resident 2 does not have access to a source of light that can be turned on/off at bedside.**Repeat violation: 3/20/25, 11/26/24, 9/17/24***Plan of Correction****Directed** [REDACTED] - 09/25/2025)*Immediately: A source of light that can be turned on/off at bedside shall be placed by residents 1 and 2's beds.**Immediately: A designated staff person shall do an initial check of all resident rooms, then at least weekly thereafter, to ensure each resident has a source of light that can be turned on/off at bedside. Documentation of checks shall be kept.***Directed Completion Date:** 09/26/2025**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.***103i - Outdated Food****14. Requirements**

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation*There was an unlabeled, undated loaf of bread in the main kitchen walk-in freezer.***Plan of Correction****Directed** [REDACTED] - 09/25/2025)*Immediately: A designee shall check all food storage areas daily including refrigerators and freezers to ensure all food items are labeled and dated. Any outdated or spoiled food shall be disposed of.***Directed Completion Date:** 09/26/2025

103i - Outdated Food (*continued*)**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.*

133.1 - Exit Signs

15. Requirements

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation*There is no exit sign posted on the gate to exit the ground floor rear courtyard. The home currently serves 33 residents.***Plan of Correction****Directed** [REDACTED] - 09/25/2025)*Immediately: An exit sign shall be placed gate to exit the ground floor rear courtyard.**Immediately: A designated staff shall conduct weekly checks to ensure all exits have signs bearing the word "EXIT" in plain legible letters. Documentation of checks shall be kept.***Directed Completion Date:** 09/26/2025**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.*

141a - Medical Evaluation

16. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation*Resident 2, whose admission date is [REDACTED] 2024, has 1 Documentation of Medical Evaluation (DME) in their record dated 3/6/2024. The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.**Resident 3, whose admission date is [REDACTED] 2024, has 2 Documentations of Medical Evaluation (DME) in their record, both indicated as their initial evaluation; one dated [REDACTED] 9/2024 and the other dated [REDACTED] /2024. The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.**Resident 4, whose admission date is [REDACTED] /2024, has 2 Documentations of Medical Evaluation (DME) in their record, both indicated as their initial evaluation; one dated [REDACTED] /2024 and the other dated [REDACTED] /2024. The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.***Plan of Correction****Directed** [REDACTED] - 09/25/2025)*Immediately: The administrator or designee shall develop and implement a tracking system to ensure medical*

141a - Medical Evaluation (continued)

evaluations are completed in accordance with regulation 2600.141(a). Documentation shall be kept.

Within 3 days of the receipt of the plan of correction: All staff persons involved with the medical evaluation process shall be educated on the required time frames of medical evaluations in accordance with regulation 2600.141a. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

141a 1-10 Medical Evaluation Information**17. Requirements**

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 2's medical evaluation, dated [REDACTED]/2024, did not include a medical diagnosis including physical or mental disabilities of the resident, if any, or allergy information.

Resident 5's medical evaluation, dated [REDACTED]/2024, did not include a medical diagnosis including physical or mental disabilities of the resident, if any, special health or dietary needs of the resident.

Resident 6's medical evaluation, dated [REDACTED]/2025, did not include a general physical examination by a physician, physician's assistant or nurse practitioner.

Repeat violation: 9/17/24 et al

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: The administrator or designated staff person shall review all current medical evaluations for accuracy and completion. Documentation shall be kept.

Within 3 days of the receipt of the plan of correction: All staff persons involved with the medical evaluation process shall be educated on the required contents of the medical evaluation. Documentation of education shall be kept in accordance with 2600.65.i.

Directed Completion Date: 09/28/2025

141a 1-10 Medical Evaluation Information (*continued*)**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.*

141b1 - Annual Medical Evaluation

18. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation*Resident 1's most recent medical evaluation was completed on [REDACTED]/2024.**Resident 2's most recent medical evaluation was completed on [REDACTED]/2024.**Resident 7's most recent medical evaluation was completed on [REDACTED] 2024. The resident's previous medical evaluation was completed on [REDACTED]/2023.***Plan of Correction****Directed** [REDACTED] - 09/25/2025)*Immediately: The administrator or designated staff person shall review all resident records to ensure an in-person medical evaluation has been completed for all residents within the past year and the medical evaluation is completed accurately and in its entirety including all required information. Documentation shall be kept.**Immediately: A resident document tracking system shall be developed and implemented to ensure all residents have a medical evaluation completed within the required timeframe. Documentation shall be kept.**Within 3 days of the receipt of the plan of correction: All staff persons involved with the medical evaluation process shall be educated that a medical evaluation shall be completed at least annually. Documentation of education shall be kept in accordance with 2600.65i.***Directed Completion Date:** 09/28/2025**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.*

162c - Menus Posted

19. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation*Menus were not posted in the Memory Care unit on 8/11/2025.***Plan of Correction****Directed** [REDACTED] - 09/25/2025)*Immediately: A designated staff person will check the home daily to ensure menus are posted in accordance with*

162c - Menus Posted (continued)

regulation 2600.162(c). Documentation shall be kept.

Directed Completion Date: 09/26/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

183d - Prescription Current**20. Requirements**

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 8/12/2025 at 9:56 AM, Lidocaine Pain Relief Patch 4% Lidocaine prescribed for resident 8, was in the home's medication cart; however, the medication was discontinued on 3/2/2025.

Repeat violation: 11/26/24, 9/17/24

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: A designee qualified to administer medications shall complete an initial and monthly audit of the medication carts, first aid kits and any other medication storage areas to ensure there are no expired or discontinued medications. Any expired or discontinued medications will be immediately discarded in accordance with the Department of Environmental Protection and Federal and State regulations. This includes prescription medications, OTC medications and CAM. Documentation shall be kept.

Directed Completion Date: 09/26/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

184a - Resident's Meds Labeled**21. Requirements**

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident 9's Quetiapine Fumerate 50 mg tab prescription dosage on the medication bubble pack, 1 1/2 tabs by mouth twice daily, does not match the prescription dosage indicated on the Medication Administration Record (MAR), 1 tablet by mouth twice daily. There is not a change of direction sticker on the bubble pack indicating a medication order change.

The pharmacy label for resident 10's Acetaminophen 325 mg tab prescription dosage on the medication bubble pack, take 2 tabs by mouth every 6 hours as needed, does not match the prescription dosage indicated on the Medication Administration Record (MAR), 2 tablets by mouth twice a day. There is not a change of direction sticker on the bubble

184a - Resident's Meds Labeled (continued)

pack indicating a medication order change.

The pharmacy label for resident 11's Gabapentin 300 mg prescription dosage on the medication bubble pack, take 1 capsule by mouth twice daily, does not match the prescription dosage indicated on the Medication Administration Record (MAR), 1 cap by mouth daily at 9:00 PM. There is not a change of direction sticker on the bubble pack indicating a medication order change.

Repeat violation: 11/26/24, 9/17/24 et al

Plan of Correction**Directed** [REDACTED] - 09/25/2025)

Immediately: A designee qualified to administer medications shall complete an initial and monthly audit of the medication carts and any other medication storage areas to ensure all prescription medications are labeled with a pharmacy label, to include: the resident's name, medication name, date prescription issued, prescribed dosage and instructions for administration and name and title of the prescriber and match the prescription. Documentation shall be kept.

Directed Completion Date: 09/26/2025

Evidence of Completion**Implemented** [REDACTED] - 12/16/2025)

See attached.

184b - Labeling OTC/CAM**22. Requirements**

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 8/12/2025 Nasonex nasal spray belonging to resident 3 was in the medication cart and was not labeled with the resident's name.

Plan of Correction**Directed** [REDACTED] - 09/25/2025)

Immediately: A designee qualified to administer medications shall complete an initial and monthly audit of the medication carts and any other medication storage areas to ensure all OTC medications and CAM belonging to residents are identified with the residents name. Documentation shall be kept.

Directed Completion Date: 09/26/2025

Evidence of Completion**Implemented** [REDACTED] - 12/16/2025)

See attached.

185a - Implement Storage Procedures**23. Requirements**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures (continued)**Description of Violation**

Resident 12 is prescribed Geri-Tussin 100 mg/5 ml, take 10 ml by mouth every 6 hours as needed. On 8/12/2025 this medication was not available in the home.

Resident 13 is prescribed Loperimide 2 mg capsule, 1 capsule every 6 hours by mouth as needed, and, Quetiapine 25 mg tab, 1 tablet by mouth every 8 hours as needed. On 8/12/2025 these medications were not available in the home.

Repeat violation: 3/20/25, 11/26/24

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Immediately: A designated staff person qualified to administer medications shall complete an initial and monthly audit of the medication cart, medication administration records and prescription orders to ensure all prescription medications are available for administration.

Within 3 days of receipt of the plan of correction: All staff persons qualified to administer medications shall be educated on the home's policy and procedures for ordering and distribution of medications and the home's policy and procedures for ordering medications to ensure all prescribed medications, including as needed "PRN" medications, are available in the home for administration. Documentation shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented [REDACTED] - 12/16/2025)**

See attached.

24. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 8/12/2025, a glucometer belonging to resident 5 was in the medication cart and was not labeled with the resident's name.

On 8/3/2025 at 7:25 AM resident 14's glucometer had a blood sugar reading of 101, however a reading of 204 was recorded in resident 14's Medication Administration Record (MAR).

On 8/2/2025 at 8:00 PM, a blood sugar reading of 215 was documented in resident 14's Medication Administration Record (MAR) however, there was not a reading for that date and time in resident 14's glucometer.

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Immediately: A designated staff person qualified to administer medications shall complete an initial and monthly audit of all glucometers in the home to ensure they are calibrate for the correct date and time, labeled with each

185a - Implement Storage Procedures (continued)

resident's name, and all blood sugar readings are recorded accurately on the MAR. Documentation shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons qualified to administer insulin shall be educated on proper documentation of blood sugar readings and ensuring glucometers are labeled. Documentation shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

185b - Medication Procedures**25. Requirements**

2600.

185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

The home's procedures for the safe use of medications and medical equipment do not include documentation of the receipt of controlled substances and prescription medications.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: the administrator or designee shall develop procedures for the documentation of the receipt of controlled substances and prescription medications. Documentation shall be kept.

Within 3 days of the receipt of the plan of correction: All staff persons qualified to administer medications shall be educated on the home's updated policy and procedures. Documentation shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

187a - Medication Record**26. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident 8 was prescribed Acetaminophen 500 mcg caplets, take two tablets by mouth three times a day as needed, start on 1/2/2025, end on 12/27/2025. This medication was observed to be in the medication cart, however this medication is not listed on resident 8's August 2025 Medication Administration Record (MAR).

187a - Medication Record (continued)

Resident 14 was prescribed Voltaren 1% topical gel, apply to BL knees QID, effective 6/9/2025, and, Medi Honey 100% topical gel, 1 application 3 times weekly effective 6/13/2025. These medications were observed to be in the medication cart, however these medications are not listed on resident 14's August 2025 Medication Administration Record (MAR).

Plan of Correction**Directed** [REDACTED] - 09/25/2025

Immediately: A staff person qualified to administer medications shall conduct an initial and monthly review of all current resident MARs and prescriber's orders to ensure all prescribed medications are documented on the resident's MAR's in accordance with regulation 2600.187(a). Documentation shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons qualified to administer medications shall be re-educated on the required documentation of MARs in accordance with regulation 2600.187(a) including the proper documentation of medication administration, medication refusals, medications not available for administration and a purpose or diagnosis for each medication. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented** [REDACTED] - 12/16/2025

See attached.

187b - Date/Time of Medication Admin.**27. Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 8/12/2025 at 8:00 AM, resident 3 was administered Hydralazine 25 mg tab. As of 8/12/2025 at 10:58 AM the Medication Administration Record (MAR) did not include the initials of the staff person who administered the medication.

On 8/12/2025 at 8:00 AM, resident 13 was administered Lidocaine 5% patch. As of 8/12/2025 at 9:32 AM the Medication Administration Record (MAR) did not include the initials of the staff person who administered the medication.

Repeat violation: 6/18/25, 4/30/25, 11/26/24, 9/17/24 et al

Plan of Correction**Directed** [REDACTED] - 09/25/2025

Immediately: The administrator or designee qualified to administer medications shall review all resident MARs at least weekly and observe at least two medication passes of each staff person qualified to administer medications for two months to ensure the proper documentation of medication administration at the time of administration. Documentation of reviews shall be kept.

Within 3 days of receipt of the accepted plan of correction: All staff persons qualified to administer medications

187b - Date/Time of Medication Admin. (continued)

shall be re-educated on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

187d - Follow Prescriber's Orders**28. Requirements**

2600.

187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 8/3/2025 at 7:25 AM resident 14's glucometer had a blood sugar reading of 101, however a reading of 204 was recorded in resident 14's Medication Administration Record (MAR); this incorrect documentation resulted in a medication error, due to resident 14 being administered 2 units of Insulin Lispro U-100/1 ml based on their sliding scale: 200-250=2 units, 251-300= 4 units, 301-350=6 units, 351-400=8 units, call MD if blood sugar is over 400.

Resident 14 is prescribed blood sugar checks four times daily, with meals and nightly. Resident 14 is scheduled to have blood sugar checks at 8:00 AM, 11:30 AM, 4:00 PM, and 8:00 PM, and to be administered Insulin Lispro U-100/1 ml based on the following sliding scale: 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, call MD if blood sugar is over 400. However, on the following dates and times resident 16's scheduled 8:00 AM blood sugar checks were not completed timely:

- 8/1, blood sugar check completed at 9:25 AM.
- 8/7, blood sugar check completed at 9:47 AM.
- 8/9, blood sugar check completed at 9:06 AM.
- 8/10, blood sugar check completed at 9:57 AM.

Repeat violation: 6/18/25, 11/26/24, 9/17/24

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: The administrator or designee qualified to administer medications shall complete an initial and weekly audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b). Documentation shall be kept.

Immediately: The administrator or designee qualified to administer medications shall review all resident MARs at least weekly and observe at least two medication passes of each staff person qualified to administer medications for two months to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b). Documentation of reviews shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons qualified to administer medication shall be re-educated on proper medication administration including documentation of medication administration, following

187d - Follow Prescriber's Orders (continued)

the orders of the prescriber and reporting medication errors. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

190b - Insulin Injections**29. Requirements**

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 8/10/2025 at 8:00 AM, 11:30 AM and 4:00 PM, staff person B, who has not successfully completed a Department approved diabetes patient education program with in the last 12 months, administered insulin to resident 14.

On 8/5, 8/6, 8/7, 8/8 and 8/12/2025 at 8:00 AM, staff person C, who has not successfully completed a Department approved diabetes patient education program with in the last 12 months, administered insulin to resident 14.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

Immediately: Staff persons B and C shall not administer insulin until the home obtains the proper documentation indicating that the staff persons have completed a Department approved diabetes patient education program.

Immediately: The administrator or designated staff person shall review the records for all staff person administering medications to ensure all staff persons administering insulin have completed a Department approved diabetes patient education program. Documentation shall be kept.

Directed Completion Date: 09/26/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

224a - Preadmission Screen Form**30. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 10's preadmission screening form, dated [REDACTED]/2024, does not include a determination that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form (continued)

Repeat violation: 11/26/24, 9/17/24

Plan of Correction**Directed** [REDACTED] **09/25/2025)**

Immediately: The administrator or designated staff person shall review all resident records to ensure all residents have a preadmission screening completed, including documentation that the home can meet the needs of the resident, and the Department's preadmission screening form is present in each resident record. Documentation shall be kept.

Within 3 days of receipt of the accepted plan of correction: The administrator or designated staff person shall create and implement a system to ensure all residents being admitted to the home have a preadmission screening completed in its entirety, to include an indication the home can meet the resident's needs. Documentation shall be kept.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented** [REDACTED] **- 12/16/2025)**

See attached.

225c - Additional Assessment**31. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 15's current assessment was completed on [REDACTED]/2025. However, the resident's previous assessment was completed on [REDACTED]/2024.

Repeat violation: 9/17/24

Plan of Correction**Directed** [REDACTED] **- 09/25/2025)**

Immediately: The administrator or designated staff person shall review all resident records to ensure all residents have a current assessment completed. Documentation shall be kept.

Within 3 days of receipt of the accepted plan of correction: The administrator or designee shall develop and implement a system to ensure all residents have an assessment completed at least annually. Documentation shall be kept.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented** [REDACTED] **- 12/16/2025)**

See attached.

32. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

225c - Additional Assessment (continued)

3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

On 8/11/2025, a bedside mobility device was observed in resident 2's room, however, the assessment for resident 2, dated [REDACTED]/2025, does not indicate that the resident has a need for a bedside mobility device.

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Immediately: The administrator or designated staff person shall review all resident records to ensure all residents have a current assessment completed accurately. Documentation shall be kept.

Within 3 days of receipt of the accepted plan of correction: All staff persons completing assessments shall be educated on the proper completion and accuracy of assessments. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented [REDACTED] - 12/16/2025)**

See attached.

227g -Support Plan Signatures**33. Requirements**

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 1's support plan dated [REDACTED]/2025 was not signed by the assessor.

Resident 2's support plan dated [REDACTED] 2025 was not signed by the resident.

Resident 6's support plan dated [REDACTED]/2023 was not signed by the assessor.

Resident 10's support plan dated [REDACTED] 025 was not signed by the assessor.

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Immediately: The administrator or designated staff person shall review all current and newly completed support plans to ensure completion including signatures of those involved in the development of the plan. Documentation shall be kept.

Within 3 days of receipt of the accepted plan of correction: All staff persons involved with the completion of support plans shall be educated on the proper completion of support plans including the required signature of persons involved with the development of support plans. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented [REDACTED] - 12/16/2025)**

See attached.

231e - No Objection Statement**34. Requirements**

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/2024. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Immediately: The administrator or designee shall review all current secure dementia care resident's records to ensure each resident record has documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit. Documentation shall be kept.

Directed Completion Date: 09/26/2025

Evidence of Completion**Implemented [REDACTED] - 12/16/2025)**

See attached.

251e - Records Availability**35. Requirements**

2600.

251.e. Resident records shall be made available to the resident and the resident's designated person during normal working hours.

Description of Violation

On 7/31/2025, resident 16 was relocating from this personal care home to another personal care home. Resident 16's [REDACTED] requested resident 16's Physician's Orders for Life-Sustaining Treatment (POLST) from staff person D be provided to the transport ambulance company. However, the staff person refused to provide the original POLST to accompany the resident during transport to their new home.

Plan of Correction**Directed [REDACTED] - 09/25/2025)**

Within 3 days of receipt of the accepted plan of correction: all staff person with access to resident records shall be educated on making resident records available to the resident and the resident's designated person during normal working hours. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/28/2025

Evidence of Completion**Implemented [REDACTED] - 12/16/2025)**

See attached.

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY

December 16, 2025

[REDACTED]
600 PAOLI POINTE DRIVE OPERATIONS LLC
600 PAOLI POINTE DRIVE
PAOLI, PA, 19301

RE: HIGHGATE AT PAOLI POINTE
600 PAOLI POINTE DRIVE
PAOLI, PA, 19301
LICENSE/COC#: 13610

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/23/2025, 10/29/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: HIGHGATE AT PAOLI POINTE

License #: 13610

License Expiration: 10/11/2025

Address: 600 PAOLI POINTE DRIVE, PAOLI, PA 19301

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: 600 PAOLI POINTE DRIVE OPERATIONS LLC

Address: 600 PAOLI POINTE DRIVE, PAOLI, PA, 19301

Phone: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 44

Waking Staff: 33

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Monitoring

Exit Conference Date: 10/29/2025

Inspection Dates and Department Representative

10/23/2025 - On-Site: [REDACTED]

10/29/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 124

Residents Served: 28

Secured Dementia Care Unit

In Home: Yes

Area: Memory care unit

Capacity: 30

Residents Served: 13

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 28

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 16

Have Physical Disability: 0

Inspections / Reviews

10/23/2025 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 11/30/2025

12/04/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/08/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 12/09/2025

Inspections / Reviews (*continued*)

12/05/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/08/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 12/14/2025

12/16/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/08/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

65i - Training Record

1. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training does not include Content of course, training source and length of the courses.

Plan of Correction

Do Not Accept [REDACTED] - 12/04/2025)

Executive Director will educate all department heads on the proper way to fill out a training record guide Executive Director or designee will monitor training sheets for two months. To be completed by 12/31/26.

Licensee's Proposed Overall Completion Date: 12/31/2025

Update: 12/04/2025

The overall completion date is too far in the future. Additionally, the date in the body of the plan does not match the date selected.

Plan of Correction

Accept [REDACTED] - 12/05/2025)

Executive Director will educate all department heads on the proper way to fill out a training record guide Executive Director or designee will monitor training sheets for two months. To be completed by 12/5/25.

Licensee's Proposed Overall Completion Date: 12/05/2025

Evidence of Completion

Implemented [REDACTED] E - 12/16/2025)

See attached.

81b - Resident Personal Equipment

2. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 10/23/2025, Resident 1 has an enabler that is not attached to their bedframe. The Enabler measures 8" x 20". The enabler is on a board that slides under the mattress and is causing a 10" gap between the enabler and the mattress.

Repeat violation 11/26/2024

Plan of Correction

Do Not Accept [REDACTED] - 12/04/2025)

On 10/29/25 Executive Director immediately removed the enabler from bed. Executive Director immediately completed an audit of all residents rooms. DHW or designee will do monthly room audits and with all new admissions. This will be done monthly for two months.

Licensee's Proposed Overall Completion Date: 01/31/2026

Update: 12/04/2025

The overall completion date is too far in the future.

Plan of Correction

Accept [REDACTED] - 12/05/2025)

On 10/29/25 Executive Director immediately removed the enabler from bed. Executive Director immediately

81b - Resident Personal Equipment (continued)

completed an audit of all residents rooms. DHW or designee will do monthly room audits and with all new admissions.

Licensee's Proposed Overall Completion Date: 12/05/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

85a - Sanitary Conditions**3. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/23/2025 at 9:49 am, The refrigerator in the Memory care unit had multiple red sticky stains in the interior.

Plan of Correction

Do Not Accept [REDACTED] - 12/04/2025)

On /10/29/25 the refrigerator was immediately cleaned by Dietary. Dietary audits are done daily and Housekeeping cleans the refrigerator weekly. Dietary, DPD Housekeeping or designee will continue to do daily and weekly audits

Licensee's Proposed Overall Completion Date: 11/28/2025

Update: 12/04/2025

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction

Accept [REDACTED] - 12/05/2025)

On /10/29/25 the refrigerator was immediately cleaned by Dietary. Dietary audits are done daily and Housekeeping cleans the refrigerator weekly. Dietary, DPD Housekeeping or designee will continue to do daily and weekly audits. House keeping, Dietary and DPD will do spot checks daily..

Licensee's Proposed Overall Completion Date: 12/05/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

101j5 - Bedside Table/Shelf**4. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident 2's bed in bedroom [REDACTED]

Plan of Correction

Accept [REDACTED] - 12/04/2025)

A bedside table was immediately placed by resident #2's beds.

Immediately: The DPD is doing daily checks of all residents rooms

to ensure each resident has a bedside table or shelf. Documentation of checks shall be kept. This is on going.

101j5 - Bedside Table/Shelf (*continued*)

Licensee's Proposed Overall Completion Date: 11/28/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 2 does not have access to a source of light that can be turned on/off at bedside.

Repeat violation 5/23/2025 and 11/26/2024

Plan of Correction

Do Not Accept [REDACTED] - 12/04/2025)

A lamp was placed in residents room at bedside immediately, On 10/23/25. On admission all resident rooms to be checked for room readiness, this will include an operable bedside lamp or other source of lighting. Also a motion light has been placed on the wall near residents bed. Executive Director will educate DPD. DPD will do weekly audits. Audits will be ongoing.

Licensee's Proposed Overall Completion Date: 11/28/2025

Update: 12/04/2025

Please indicate dates for each step.

Plan of Correction

Accept [REDACTED] - 12/05/2025)

On 10/23/25 a lamp was placed in residents room at bedside immediately. On admission all residents rooms to be checked for room readiness, this will include an operable bedside lamp or other source of lighting. On 10/30/25 a motion light has been placed on the wall near residents bed. Executive Director will educate DPD. On 10/23/25 DPD started daily audits. On 12/4/25 DPD started weekly audits for Function of batteries in motion light.

Licensee's Proposed Overall Completion Date: 12/05/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 12/16/2025)

103i - Outdated Food

6. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an unlabeled, undated container of peaches in the memory care refrigerator.

Plan of Correction

Do Not Accept [REDACTED] - 12/04/2025)

Immediately the the food was taken out of the refrigerator. Dietary Director and DPD will monitor the refrigerator at least daily on each shift to ensure sanitary conditions are maintained. Documentation shall be kept. staff shall be re-educated on maintaining sanitary

103i - Outdated Food (continued)

conditions including immediately correcting or reporting any unsanitary conditions. This will be ongoing

Licensee's Proposed Overall Completion Date: 11/28/2025

Update: 12/04/2025

Please indicate dates for each step.

Plan of Correction

Accept [REDACTED] - 12/05/2025)

On 10/23/25 Dietary Director Immediately removed the food out of the refrigerator. On 10/23/25 Dietary Director and DPD will monitor the refrigerator at least daily to ensure sanitary conditions are maintained. Documentation shall be kept.

staff shall be re-educated on maintaining sanitary

conditions including immediately correcting or reporting any unsanitary conditions. This will be ongoing

Licensee's Proposed Overall Completion Date: 12/05/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

141a 1-10 Medical Evaluation Information**7. Requirements**

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 3's medical evaluation dated [REDACTED]/24 did not include a medical diagnosis including physical or mental disabilities of the resident, if any, medical information pertinent to diagnosis and treatment in case of an emergency, immunization history, special health or dietary needs of the resident.

Plan of Correction

Do Not Accept [REDACTED] - 12/04/2025)

DHW immediately started chart checks. All new state paperwork on all residents has been started. DHW or designee will start a new tickler to ensure all state paperwork is in compliance. To be completed by 12/31/25

Licensee's Proposed Overall Completion Date: 12/31/2025

Update: 12/04/2025

The overall completion date is too far in the future.

141a 1-10 Medical Evaluation Information (continued)

Plan of Correction

Accept [REDACTED] - 12/05/2025)

On 10/23/25 DHW immediately started chart checks. All new state paperwork on all residents has been started. DHW or designee will start a new tickler to ensure all state paperwork is in compliance. To be completed by 12/12/25

Licensee's Proposed Overall Completion Date: 12/05/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

187d - Follow Prescriber's Orders

8. Requirements

2600.

187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 3 is prescribed Spironolactone 50mg tab. However, resident 3 was not administered Spironolactone 50mg tab on 10/7/2025 at 8:00 am.

Resident 4 is prescribed Nasonex 50mcg spray. However, resident 4 was not administered Nasonex 50mcg spray on 10/7/2025 at 8:00 am.

Resident 5 is prescribed Acetaminophen 325mg by mouth every 8 hours for pain. However, resident 5 was not administered Acetaminophen 325 mg on 10/10/2025 at 3:00 pm.

Resident 6 is prescribed Vitamin B-12 1000mcg tab 1 tab by mouth daily at 8:00 am. However, resident 6 was not administered VitaminB-12 1000mcg tab on 10/7/2025 at 8:00 am.

Resident 6 is prescribed Insulin Lispro U-100/1ML sliding scale: 200-250= 2 units; 251-300= 4 units; 301-350= 6 units; 351-400= 8 units four times daily. On 10/23/25 at 0800 Resident 6 had a blood sugar reading of 224 and they should have been administered 2 units of insulin, the home administered 0 units.

Resident 7 is prescribed Vitamin D3 25mcg (1000IU) 1 tablet by mouth daily at 8:00 am. The home had 50mcg (2000IU) present in the medication cart.

Resident 8 is prescribed Red Yeast Rice 1200mg capsule 1 capsule by mouth twice daily at 8 am and 5 pm for supplement. The home had 1800 mg Red Yeast rice present in the medication cart.

Resident 8 is prescribed Armour Thyroid 30mg Tab 1.5 tablets by mouth daily before breakfast at 6:00 am. On 10/3/2025 Armour Thyroid was not administered at 6:00 am.

Repeat violation, 6/18/2025, 11/26/2024

Plan of Correction

Accept [REDACTED] - 12/04/2025)

The DHW or designee qualified to administer medications shall complete an initial and weekly audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs.

187d - Follow Prescriber's Orders (continued)

Documentation shall be kept.

The DHW or designee qualified to administer medications shall review all resident MARs at least weekly and observe at least two medication passes of each staff person qualified to administer medications for two months to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs. Documentation of reviews shall be kept.

Within 5 days of receipt of the plan of correction: All staff persons qualified to administer medication shall be reeducated on proper medication administration including documentation of medication administration, following.

Licensee's Proposed Overall Completion Date: 12/12/2025

Evidence of Completion

Implemented [REDACTED] - 12/16/2025)

See attached.

225c - Additional Assessment**9. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 3's most recent assessment was completed on [REDACTED]/2024.

Resident 7's most recent assessment was completed on [REDACTED]/2024.

Resident 9's most recent assessment was completed on [REDACTED] 2024.

Resident 10's most recent assessment was completed on [REDACTED]/2024.

Resident 11's most recent assessment was completed on [REDACTED]/2024.

Plan of Correction

Do Not [REDACTED] - 12/04/2025)

A Chart audit was completed. DHW or designee will do all new state paperwork on all residents. A tickler was created. DHW will be educated by Executive Director on the compliance. This will be completed by 12/31/25.

Licensee's Proposed Overall Completion Date: 12/31/2025

Update: 12/04/2025

The overall completion date is too far in the future.

Plan of Correction

Accept [REDACTED] - 12/05/2025)

On 10/23/25 A Chart audit was completed. DHW or designee will do all new state paperwork on all residents. A tickler was created. DHW will be educated by Executive Director on the compliance. This will be completed by 12/12/25.

Licensee's Proposed Overall Completion Date: 12/05/2025

225c - Additional Assessment (*continued*)**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.*

227g -Support Plan Signatures

10. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 9 participated in the development of h[REDACTED]r support plan on [REDACTED]/2024. However, the resident did not sign the support plan.

Plan of Correction**Do Not Accept** [REDACTED] - 12/04/2025)

DHW or designee will check all resident Support plans before they are placed in residents chart. All new support plans are being completed and will be on going. A tickler was created.

Licensee's Proposed Overall Completion Date: 12/31/2025**Update:** 12/04/2025

The overall completion date is too far in the future.

Please include dates for each step.

Plan of Correction**Accept** [REDACTED] - 12/05/2025)

On 10/23/25 DHW or designee checked all residents Support plans . Before they are placed in residents chart DHW will ensure that care plans have residents signature on them. On 10/23/25 all new support plans are being completed and will be on going. A tickler was created.

Licensee's Proposed Overall Completion Date: 12/05/2025**Evidence of Completion****Implemented** [REDACTED] - 12/16/2025)*See attached.*